STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967353	08/31/2015
NAME OF PROVIDER OR SUPPLIER **CALVINELLE ADULT HOME ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1627 NW 62 TERRACE** **MIAMI, FL 33140**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

A Limited Nursing Services Monitoring Survey was conducted on , 2015. Calvinelle Adult Home ALF with Limited Nursing Services and Limited Mental Health had a deficiency identified under surveyed component at time of survey.

0078 Staffing Standards - Staff

Based on record review and interview facility failed to document freedom from on an annual basis of Registered Nurse contracted by facility to provide limited nursing services.

Findings included:

Record review of contracted Registered Nurse revealed that the last statement was dated and was negative.

Caregiver stated on / at 10:00 am that she acknowledged the finding and that she would let the administrator know about the deficiency.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Calvinelle Adult Home Alf
1627 Nw 62 Terrace
Miami, FL 33140

Dear Administrator:

This letter reports the findings of a Limited Nursing Services Monitoring Survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure

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